DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2645 (Rev. 5-06)

STATE OF WISCONSIN

CANCER AND CHRONIC DISEASES DRUG REPOSITORY PROGRAM
RECIPIENT RECORD

Completion of this form meets the requirement of Wisconsin Administrative Code s. HFS 148.07(3) for dispensing drugs or medical supplies to recipients who meet the eligibility requirements of s. HFS 148.05. Questions about completion of this form may be directed to 608-266-5388.

Name – Recipient (print)	Date Received

NOTE: The pharmacy may place a copy of the label on this form in lieu of entering the following information.

Name – Medication

Medication Strength	Expiration Date	Quantity Received

I certify that I am a Wisconsin Resident and that I understand that the medication I am receiving has been donated and has potentially been stored in a non-controlled environment. I understand that the pharmacy, pharmacist and manufacturer cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.

SIGNATURE – Recipient	Date Signed